The “Golden Hour”: The challenges facing healthcare providers, their responses, and implications for purchasers

CalPERS Board Session

Discussion document
December 13, 2011

Today's discussion

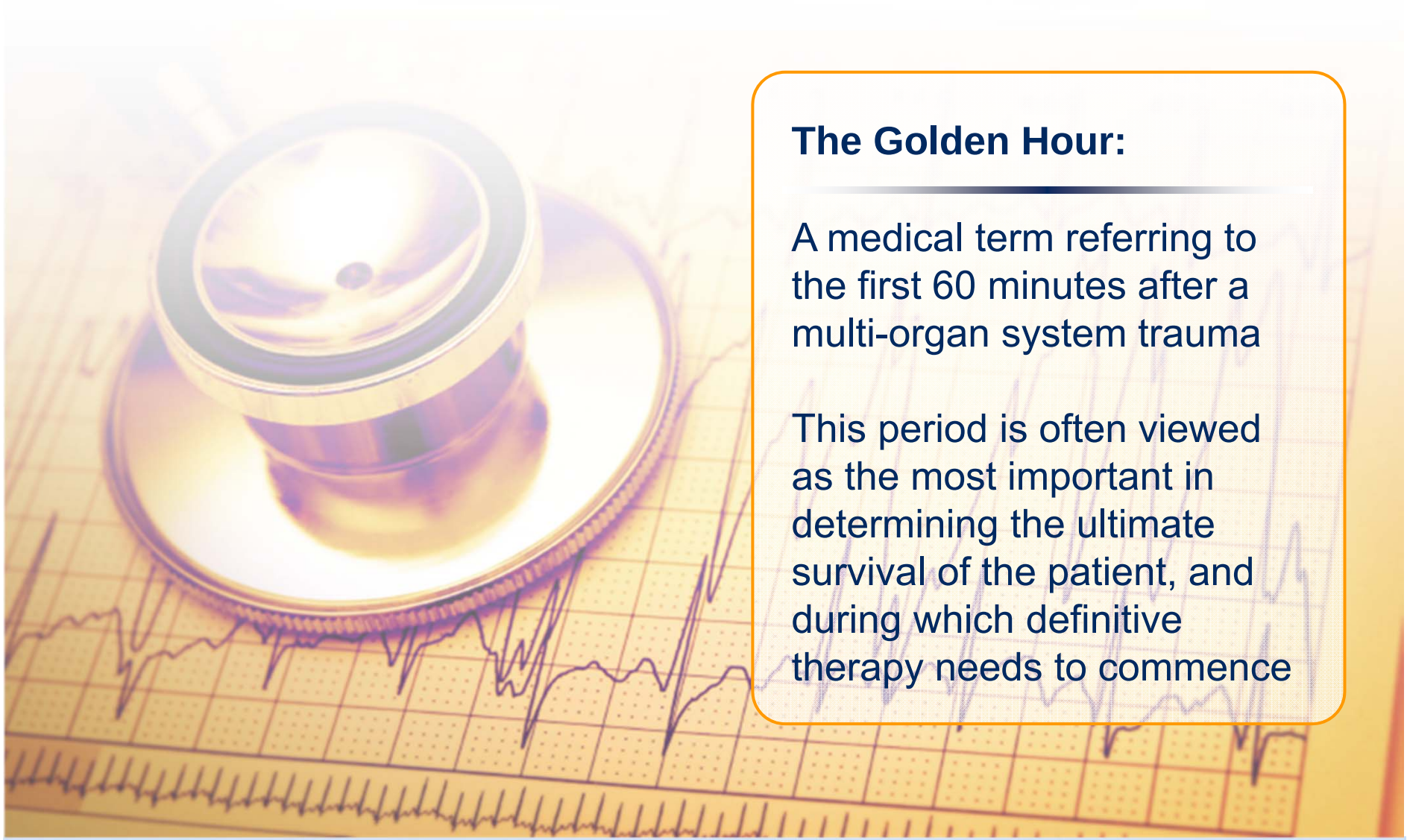
The current provider environment

Near-term challenges

Strategic responses

What this means for provider / payer relations

A “Golden Hour” for health care providers

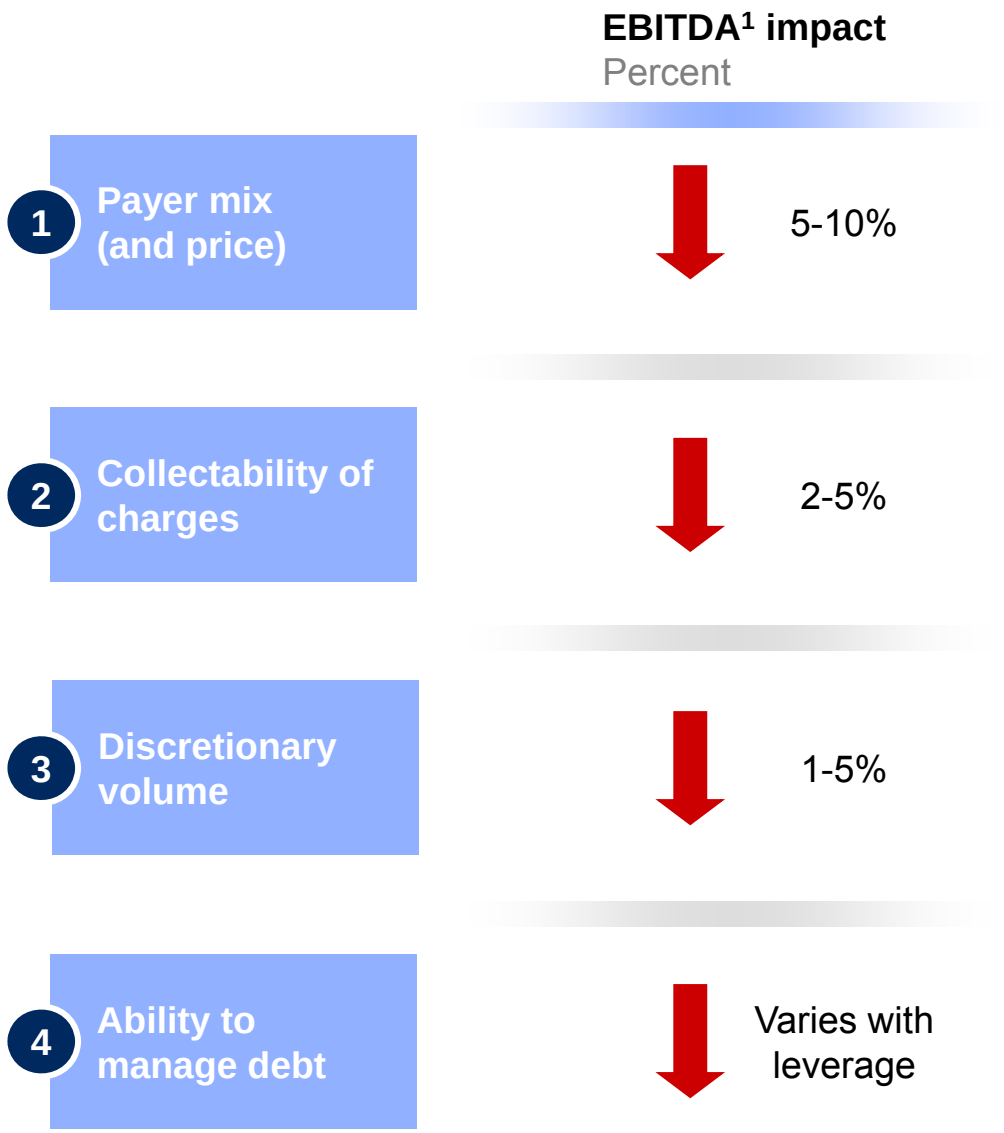


The Golden Hour:

A medical term referring to the first 60 minutes after a multi-organ system trauma

This period is often viewed as the most important in determining the ultimate survival of the patient, and during which definitive therapy needs to commence

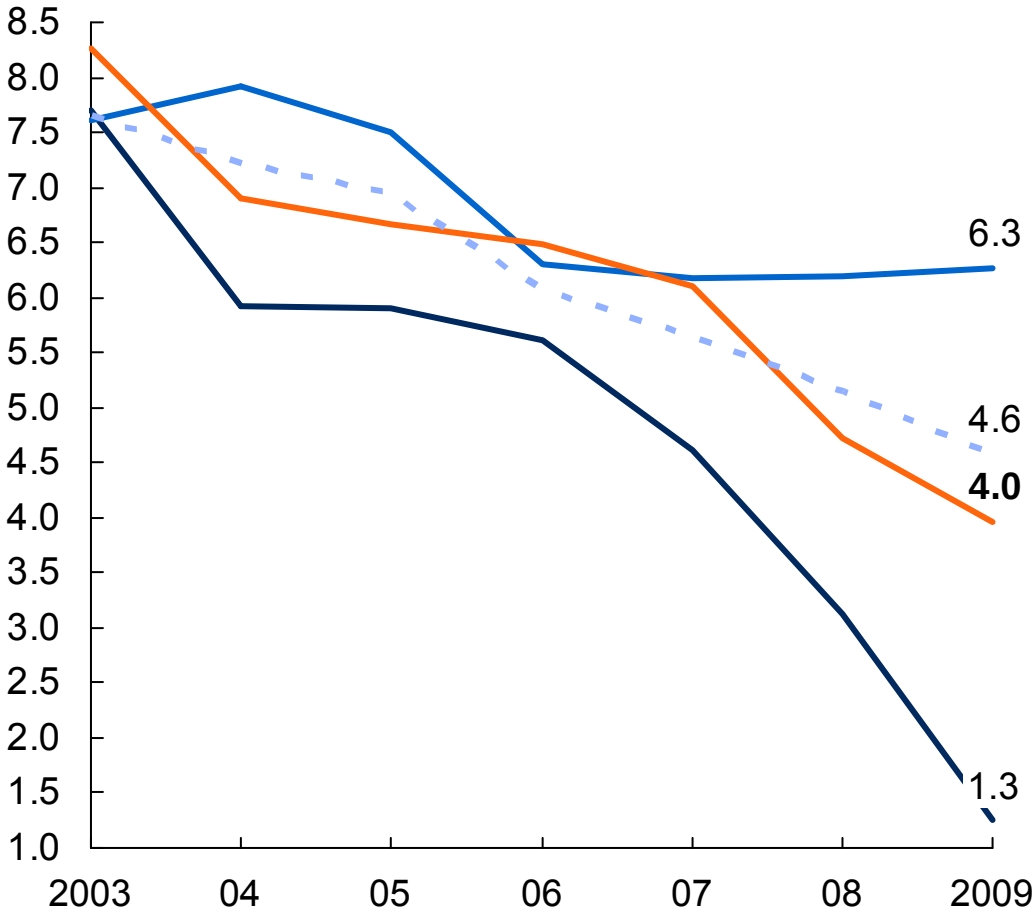
In 2009, we argued that providers were facing a “golden hour” as a four challenges emerged which threatened traditional business models



1 EBITDA = Earnings Before Interest, Tax, Depreciation, & Amortization
SOURCE: McKinsey analysis

These specific challenges occurred against the backdrop of an historic slow down in health care spending growth

Growth in spending on inpatient and outpatient care vs. total national health expenditure (NHE) %



- Outpatient care the second fastest growing segment of the health economy between 2006-09 (behind long-term and home care)
- Accounted for 40% of spending in 2009 and 50% of growth between 2006-09

- Growth in inpatient care declined by an average of 1.5% each year between 2006-09

SOURCE: Centers for Medicare & Medicaid Services; McKinsey analysis

The “Golden Hour” now in full force: 2011 as the year of missed budgets

Key trends in 2011 provider outlook

- Accelerated transition in payer mix away from Commercial and Medicare towards Medicaid and Self-pay across both elective and emergency department (ED) channels
- Volume growth driven primarily by outpatient visits. Within outpatient, growth driven by ED visits (vs. elective)
- Declining Medicare acuity and stalled growth in surgical acuity putting downward pressure on unit pricing. Concurrent shift of cardiovascular inpatient (IP) mix shift from surgical to medical cases
- Negative effects from changes in reimbursement rules including Medicaid and subsidy cuts (in some states), Medicare 72-hour rule and enhanced enforcement of IP/Observation status, and Cat Scan (CT) reimbursement changes

Impact for some for-profit systems

- HCA missed 2Q earnings driving shares down ~20%
- Tenet revised guidance on 2011 EBITDA to low range of prior $1.18B – $1.28B target due to weakness in 3Q

SOURCE: Press search. HCA Second Quarter Review, September 12, 2011; Tenet Healthcare Investor Meetings presentation, September 27 – 30, 2011; company websites; McKinsey Analysis

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The Accountable Care Act (ACA) is expected to impact providers economically in six primary ways

1. **Increase in insured population and utilization** due to coverage expansion in commercial and Medicaid

2. **Medicare growth rate declines** (up to 2% less compounded) and penalties for not hitting quality targets

3. **Reductions in DSH (disproportionate share) payments** which will vary by state

4. **Medicaid reimbursement reductions** to close the unfunded portion of the reform-mandated coverage expansions

5. **Cadillac tax** will have a modest impact prior to 2020 but intensify afterward

6. **Medicare wage index reformulation** which, if passed per MedPAC recommendations, could adversely impact some regions

In addition to these changes brought about by the ACA, providers are also preparing for a number of other near-term challenges

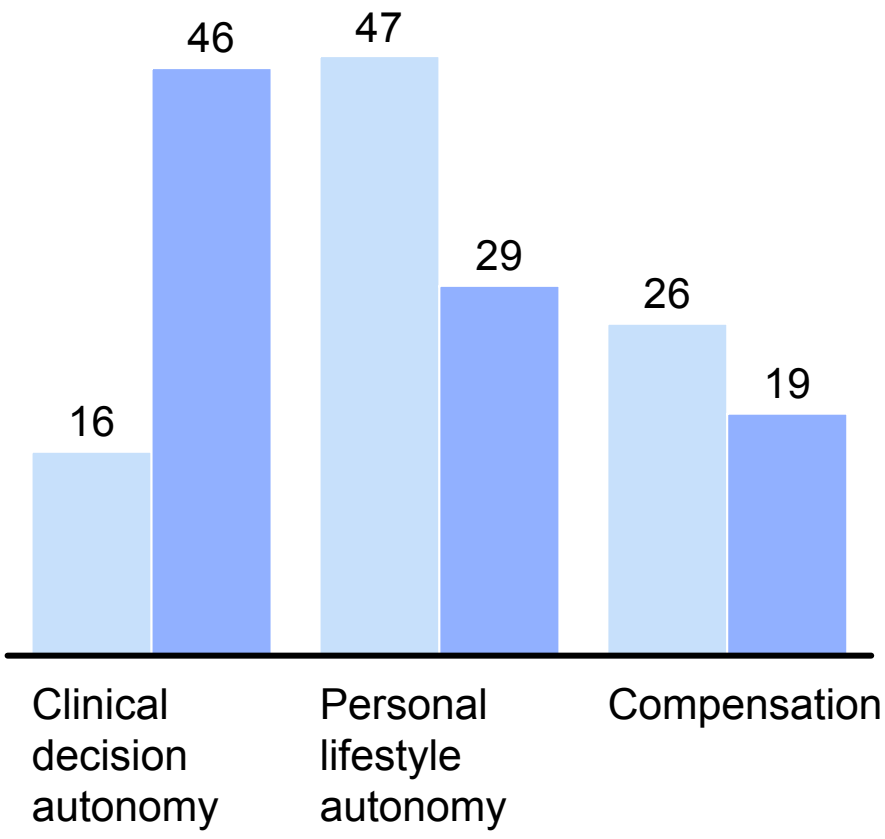
1. Meaningful use and electronic medical record (EMR) deployment
2. ICD-10[1]
3. Full impact of RAC (post-discharge) audits and associated workflow
4. Uncertainty over Medicaid and supplement-based reimbursement
5. Increased complexity of revenue cycle with plan diversity and greater consumer balances

1 ICD = International Classification of Disease

Amidst this uncertainty, physicians expect that they will face difficult personal and professional trade-offs

Factors likely to suffer under employment models

Percent (larger bars are less desirable)



- Most physicians feel **personal autonomy** would suffer most with **hospital** employment
- Most physicians feel **clinical autonomy** would suffer most with **insurer** employment

SOURCE: McKinsey's 2011 Physician Survey, preliminary findings as of October 10 (n = 782)

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How are providers responding? There are many responses, but 4 have been particularly common

1. Enacted broad-ranging cost control programs, including lean operations (throughput), back-office cost control, and clinical variability reduction ("Medicare margin" efforts)

2. Engaged in a frenetic wave of transactions (merger & acquisitions) across the for-profit, not-for-profit, and outpatient-focused spectrum

3. Continued to move towards greater physician alignment through structural options (employment and "employment-like" in strong CPOM[1] states). Now evolving towards innovative incentive relationships (e.g., Accountable Care Organization-like (ACO-like) or "Clinical Integration"-based)

4. Continued to invest heavily in services and specialists with differential reimbursement and margin (leading to "tragedy of the commons" in some services)

1 CPOM: Corporate Practice of Medicine doctrine (preventing direct employment per State legal precedent on restricting corporate entities from the practice of medicine through direct employment of physicians

1 Many health systems are responding by rethinking lean operations and clinical variability reduction ("Medicare Margin" efforts)

Example: Change program in 30+ hospital system focused on quality and operations solutions across entire network.

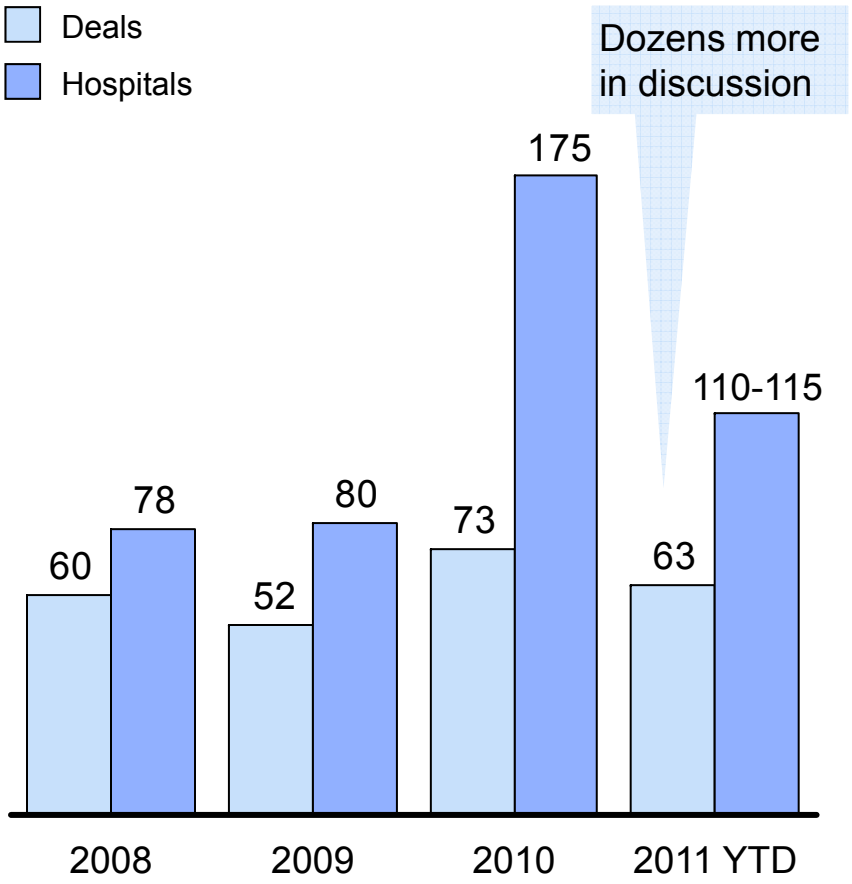
Typical impact observed:

- Cut rate of pressure ulcers in half
- Eliminated use of high-cost overtime nurse pool through discharging patients 90 mins earlier on average
- Sustained 3 hour emergency department (ED) length of stay (LOS) reduction 12 months after implementation
- Built capabilities of ~650 employees through engagement in designing and implementing solutions

2 Transactions and alliances are proceeding at an accelerated pace in 2011

Hospital mergers and acquisitions

2008-2011 YTD

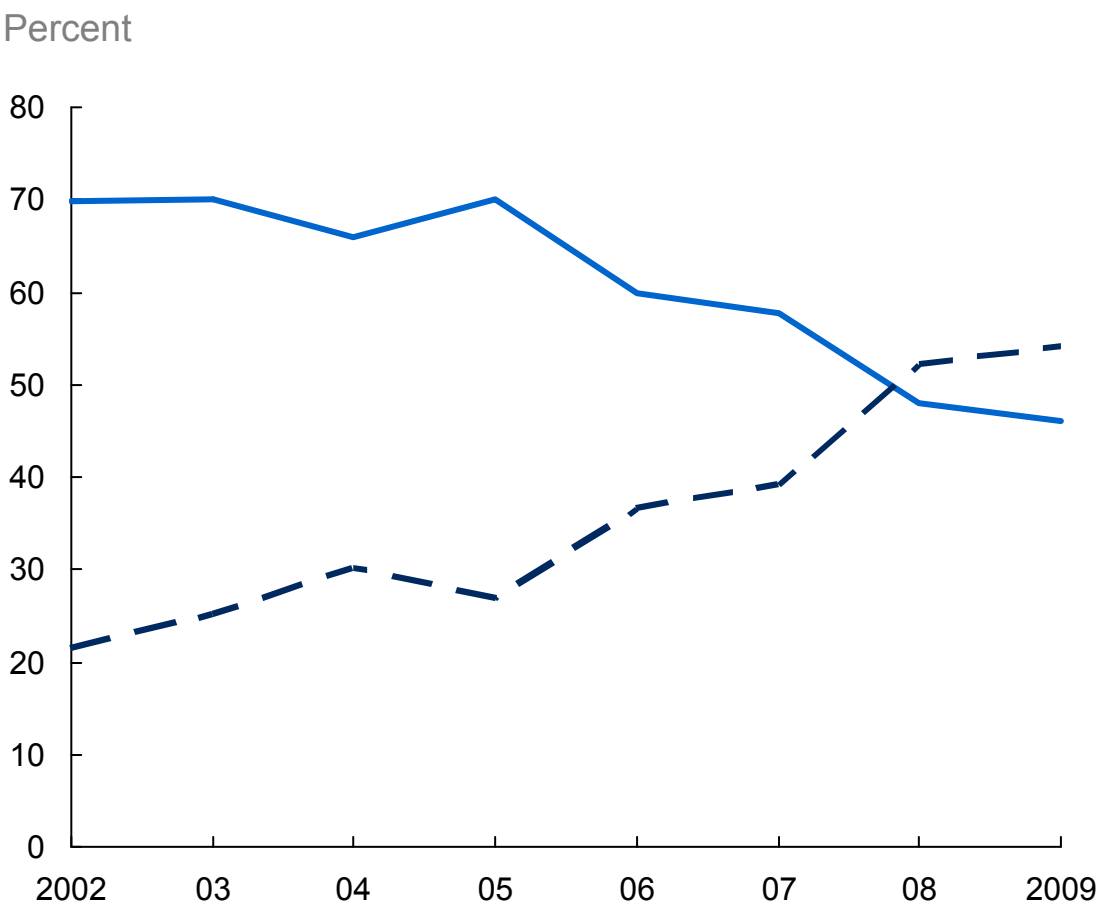


Some prominent recent examples (of actual or proposed deals)

UHS
PSYCHIATRIC SOLUTIONS, INC. PSI
VANGUARD HEALTH SYSTEMS
DMC DETROIT MEDICAL CENTER
SWEDISH
PROVIDENCE Health & Services
HCA Hospital Corporation of America
Health ONE
CERBERUS CAPITAL MANAGEMENT, L.P.
Steward Steward Health Care System

3 Structural alignment with physicians (through employment/ownership) has accelerated, though novel alignment methods gaining recently

U.S. physician practice ownership

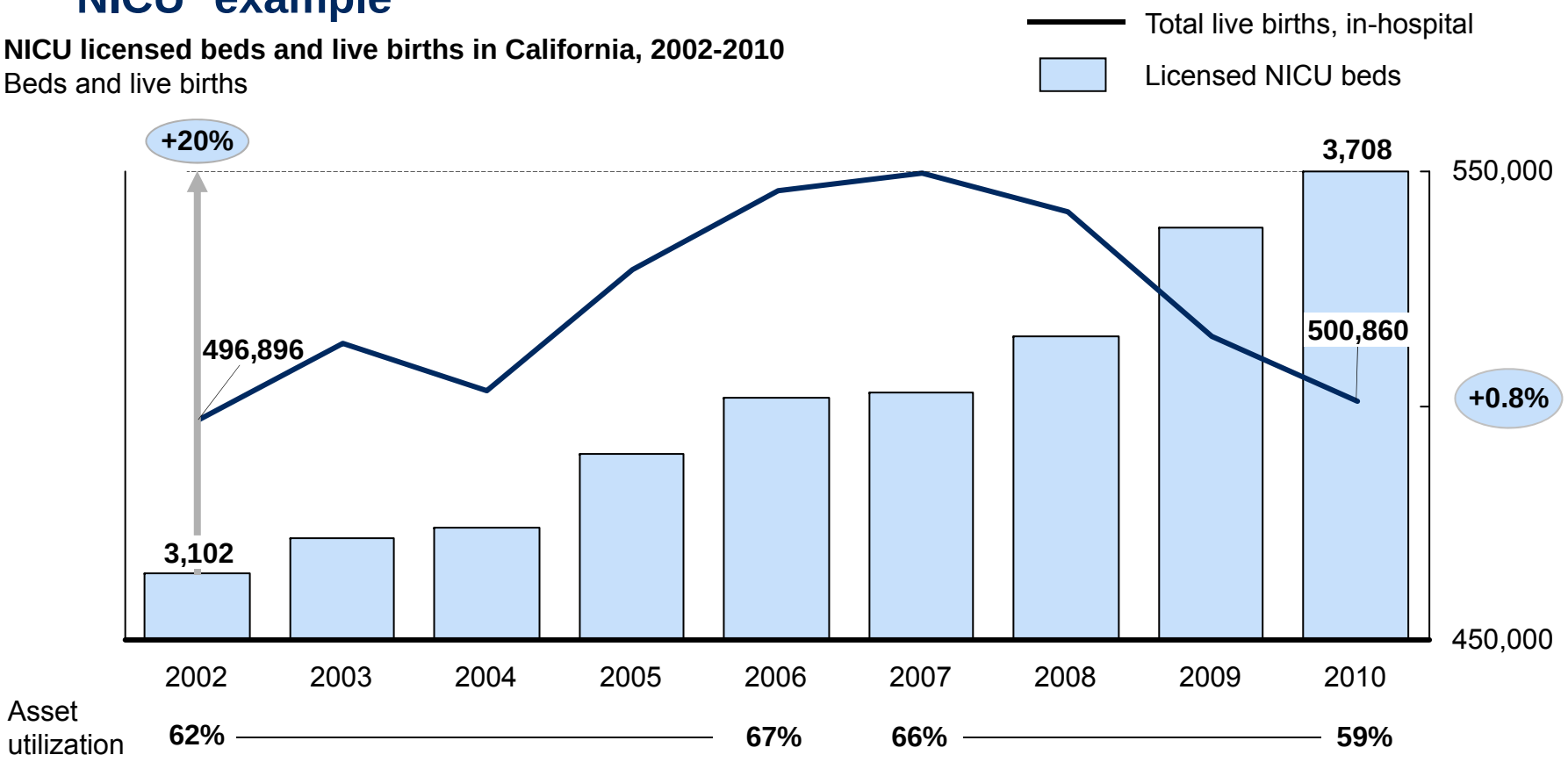


- Many health systems now rethinking their approach to full employment (or foundation/friendly PC) given the debacles of the 1990s
- New approaches attempt to capture behavior alignment with more limited financial responsibility:
  - Clinical integration
  - CMS bundling with gainsharing
  - Private ACO-like arrangements

SOURCE: Physician Compensation and Production Survey, Medical Group Management Association, 2003- 2009

4 (Over-?)investing in highly reimbursed and specialized services: NICU[1] example

NICU licensed beds and live births in California, 2002-2010
Beds and live births



- California's story has been replicated in many markets and for many high-end services:
  - Many competitors note differential profitability and potential to invest in growing/building the service
  - "Everyone" builds into perceived growth (in this case, birth rate in mid-decade)
  - Intrinsic market shifts in demand (in this case, a 10+% dropoff in births post recession)
  - Overcapacity in market and pressures on utilization lead to missed expectations, further stress on budgets with a ballooned fixed cost base (and the lack to "flex down" quickly or at all)

1 NICU= Neonatal Intensive Care Unity
SOURCE: McKinsey analysis of OSHPD ALIRTs reporting, 2002-2010
Note: California is a non-CON state

Looking forward, there are several important “CEO” level topics for providers to address

Focus of next few pages

Capture a disproportionate share of the newly commercially insured
Target newly covered lives with appropriate care offerings

Build sustainable Medicare care models
Translate efficiencies into growth and positive margins for Medicare population

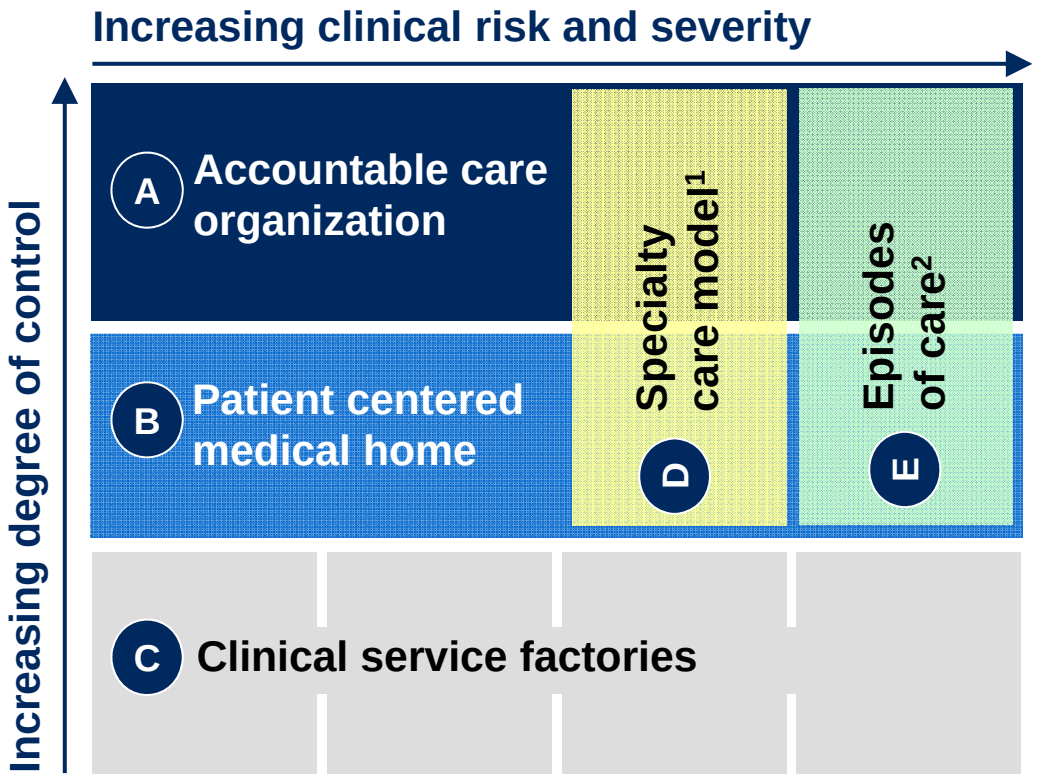
Manage the surge of Medicaid patients
Reconsider strategy for this population based on cost structure and delivery models

Assess how far to go with integration and coordination (virtual and real)
Consider emerging models of accountable care organizations and other innovations

Invest in world-class functions and capabilities
Creating distinctive capability in infrastructure that addresses value over volume

Focus on health care, not hospital care: expand the continuum
Building scale through mergers, acquisition, and collaboration with hospitals and physicians

We are seeing the emergence of 5 innovative care and payment models



SOURCE: McKinsey Care Delivery and Payment Model Innovation Toolkit V 1.0

A variety of players are experimenting with care delivery and payment innovation

	Select examples	
A Accountable care organization	CalPERS, Blue Shield, CHW, Hill Physicians	CalPers, Blue Shield, Catholic Healthcare West, Hill Physicians
	Massachusetts BlueCross BlueShield of Minnesota	Alternative Quality Contracts and Shared Incentive Model
B Patient centered medical home	HUMANA. Guidance when you need it most	Medicare Advantage, Florida
	CareFirst BlueCross BlueShield	All members, Maryland
C Clinical service factories	abilito	Remotely-enabled psychiatric services
D Specialty care model	UnitedHealthcare	Oncology; support from National Comprehensive Cancer Network (NCCN)
E Episodes of care	Horizon Blue Cross Blue Shield of New Jersey	Orthopedics

SOURCE: McKinsey Care Delivery and Payment Innovation Toolkit V 1.0

Sacramento ACO achieved cost of care savings through virtual integration

Care model

ACO started in January 2010 for 42,000 California public employee retirement program (CalPERS) HMO members

Impact

- **$20M savings** in 2010
- **Hospital readmissions** declined by 17%; **Avg. LOS (ALOS)** was reduced by a half-day; **total patient inpatient** days fell by 14%

Value levers

- **Care pathways:** ALOS; increase generic drug use; new Utilization Management
- **Clinical variability reduction**
- **Appropriate venue of care**
- **IT integration of data**

Value chain strategy

Virtual integration model among CHW, Hill Physicians and Blue Shield CA involving pooled risk and gain sharing based on quality and cost efficiency performance measures

Characteristics favoring formation

Overall, the ACO stakeholders faced a compelling imperative given the number of lives involved, increasing cost pressures, and considerable competition from regional providers Kaiser Permanente and Sutter Health

1 Sutter Health, CHW, Kaiser Permanente, & UC Davis Health system
2 Based on Inpatient Discharges at time of founding

SOURCE: Team analysis

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The balance of "venues for collaboration" and "tendency to self-optimize" will determine the future of provider and payer relationships by market

Potential venues for collaboration

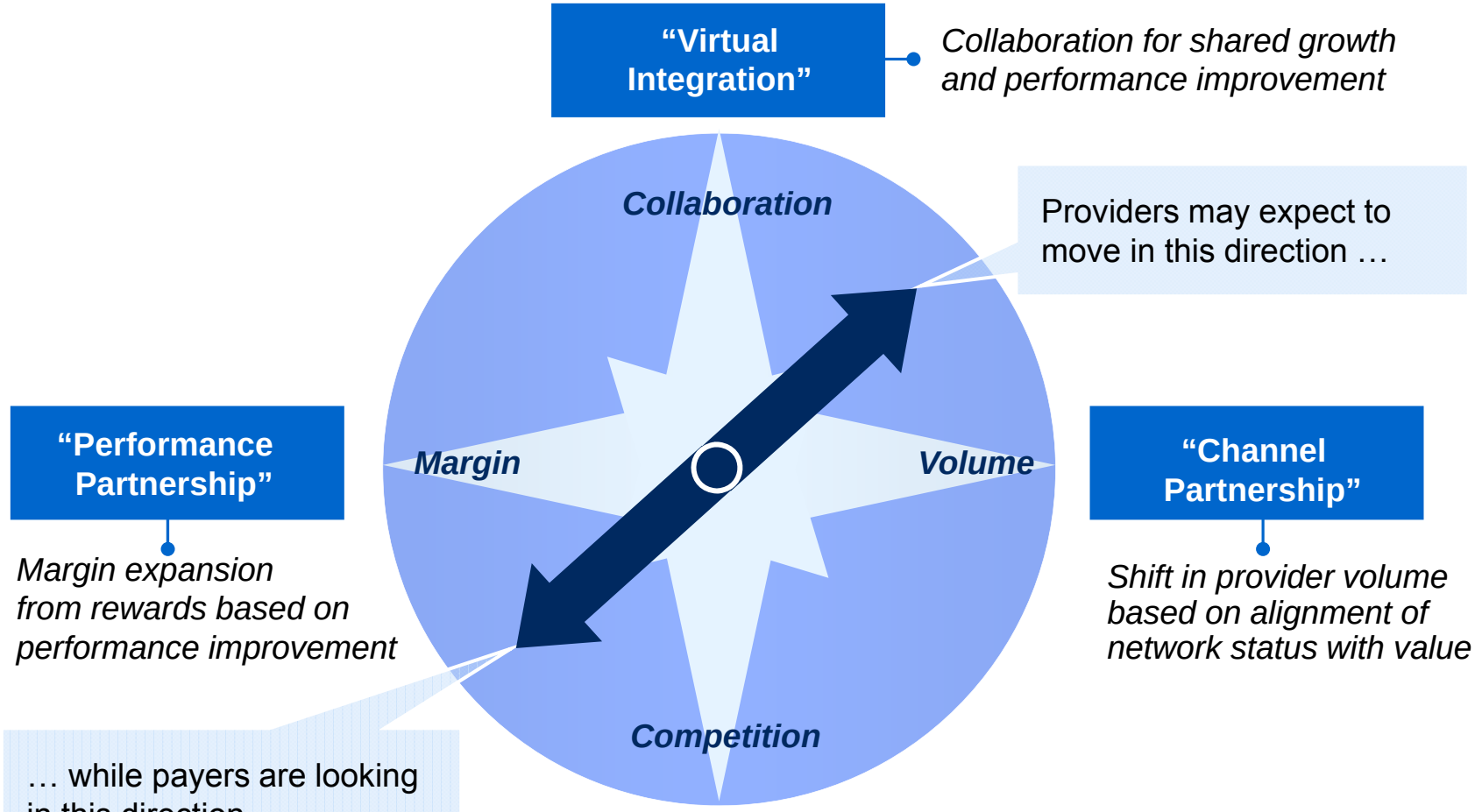
- Physician behavioral change to reduce clinical variability
- Common stakeholder business interest
- Third party expense control (e.g., pharma/med device)
- Performance-based incentives
- Minimize non-value add cost centers
- Data and information exchange

Important to consider venues for collaboration and the business models that support it versus only focusing on competitive tendencies

Competitive (self-optimizing) tendencies

- **Providers**
  - Using/enhancing scale and leverage to be "must have"
  - Buildout/growing highly reimbursed services
  - Launching provider-sponsored plans (often in MA/Medicaid)
- **Payers**
  - Using/enhancing scale and leverage to be "must have"
  - Leveraging the primary care provider as a controlling force for trend
  - Integrating across the payer-provider spectrum to gain alignment and coordination

Also complicating relationships is tendency for providers and payors to think differently about value extraction



SOURCE: McKinsey Care Delivery and Payment Innovation Toolkit V 1.0

A “new world order” of health systems may emerge as the external environment evolves

FOR DISCUSSION

What “archetypes” may emerge after the dust settles?

Technical Fee Addict (stays addicted)

- Extracts unusual margin from “activity based” reimbursement

Academic or Tertiary Powerhouse

- Extracts (enhances) market premium prices from brand or unique services

Innovative market consolidator

- Aggressively creates structural linkages across the continuum (using it for innovation or for leverage)

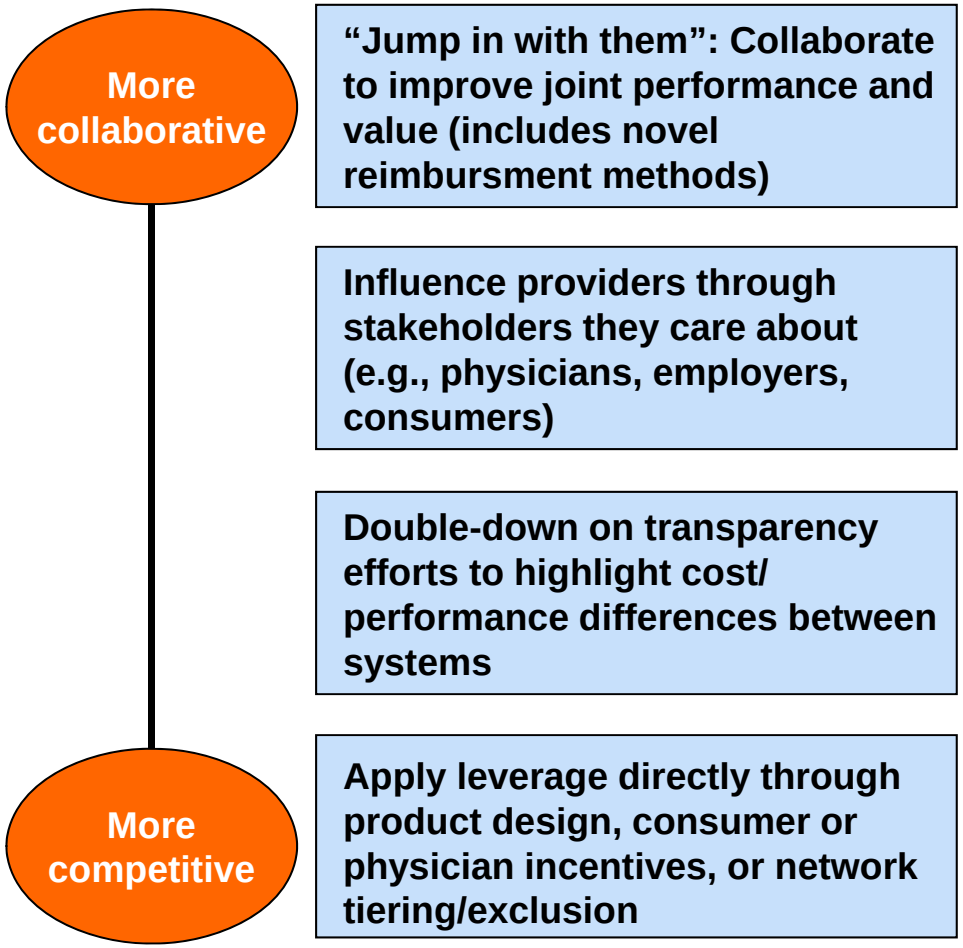
Health Reform Innovator

- Embraces innovative elements of reform including performance risk

How will this impact the future of payor-provider collaboration?

What potential paths are there to influence provider response?

ILLUSTRATIVE



Is it better to choose one model or employ a variety (portfolio)?

How transparent should health plan provider strategy be advertised to providers?

Are there timing differences in the effectiveness of these levers?

Some concluding thoughts on a complex environment

1. Providers are facing a “golden hour” that is playing out in “full force” in 2011, with significant concern over the future

2. The innate responses of health systems varies from the adaptive (cost control, leaning out processes) to uncertain (merger & acquisition binge) to the potentially maladaptive (buying up docs, overinvesting in high end service lines)

3. The future of payer/provider relationships will depend on the balance of opportunities and threats to the respective business models, and the push to collaborate versus compete (“frenemies”)

4. Payers can play an important role in shaping provider response, with the optimal stance depending on how providers are reacting and to the local market conditions. Payers that can more proactively influence “adaptive” behavior and responses should stand to create a more sustainable platform regardless of how ACA and other regulatory issues play out in the coming years.

So what does all this mean for CalPERS?

- Uncertainty in the market may drive CalPERS into may shorter-term contracts with options to extend in the next cycle
- CalPERS can further align incentives in the system by driving accountability across:
  - Integrated care and performance-based contracts across payors & providers
  - Wellness programs and moving costs from monthly premiums to point of service payments
- Providers may be more willing to trade price for volume commitments creating greater benefit from narrow networks
- Push toward overall health and wellness of the population through quality transparency and wellness / Chronic Disease management